EXECUTIVE SUMMARY

PURPOSE

To determine the effectiveness of Health Maintenance Organizations' (HMOs) processing of Medicare beneficiary appeals and grievances through on-site reviews.

BACKGROUND

Beneficiaries may join a risk HMO through the Medicare program. For a predetermined monthly amount, the HMO provides Medicare covered medically necessary services. The goals of this coverage are to provide coordinated medical care, offer comprehensive benefits, and contain costs by using the most cost-efficient methods of treatment and preventing unnecessary care. As a protection for beneficiaries, the Social Security Act requires Medicare HMOs to have two separate and distinct processes, an appeal and a grievance process, to handle beneficiary complaints.

In order to protect beneficiaries from inappropriate denials of services or payment, the Act requires that Medicare HMOs establish an appeal process to handle these types of complaints. If an enrollee disagrees with the HMO decision to deny services or payment, the enrollee has 60 days to file a request for reconsideration. If the HMO's decision is against the beneficiary in whole or in part, the HMO is required to automatically send the case to the Network Design Group within 60 days for an independent Federal review.

All other complaints such as those relating to quality of care are processed under a separate internal grievance procedure. Under this procedure, there are no specific time frames or preordained levels of review established by law. However, HMOs are responsible for timely transmission, an investigation, decision, and notification of the results.

From a universe of 132 risk-based HMOs, we selected a purposive sample of 10 HMOs for on-site review. To provide a cross-section, HMOs were selected by number of enrollees, rate of appeals sent to Network Design Group, beginning contract date, location, and other criteria. Within the sampled HMOs, we randomly selected cases for review (144 appeals and 148 grievances) and analyzed them to determine whether procedural guidelines were followed, if complaints were being properly categorized, if time requirements were being met, and if problems or weaknesses existed in the appeal/grievance processes.

FINDINGS

Beneficiaries were not always advised of their appeal rights at the time services or payment were denied.

Regulations require HMOs to issue a written "initial determination" of denials and to advise patients of their right to request a reconsideration (appeal). Twenty-seven

percent of sample case files did not have initial determinations on file, 5 HMOs sent them without including the required appeals rights (6 cases), and 5 more sent the notice to beneficiaries after receiving their appeals (12 cases).

The HMOs did not properly distinguish appeals from grievances.

HMOs incorrectly processed appeal issues as grievances in 37 cases. This represents 26 percent of the 148 grievances we examined. Every plan made at least one such error. In addition, three incorrectly processed five complaints that included both appeal and grievance issues. The distinction between appeals and grievances is important to beneficiaries because appeal cases (denials of services or payment) are subject to independent Federal review for appropriateness of the HMO decision while grievances are only subject to internal HMO reviews.

The HMOs did not fully comply with Health Care Financing Administration (HCFA) directives for processing appeals and grievances.

Processing Appeals. Five HMOs did not refer eight denied cases to Network Design Group. Three did not document the basis for "good cause" for accepting 14 cases filed after 60 days. Five sent beneficiaries multiple initial determinations in nine cases. In addition, 5 HMOs had 13 cases where beneficiaries appealed several times before the plans would begin the appeals process.

Time Frames for Appeals. Five HMOs did not issue the initial determination within 60 days of the beneficiary's initial request for services or payment in 11 cases. One HMO waited two years before sending two cases to Network Design Group and resolution took five years. Nine plans did not make the reconsideration determination within 60 days or inform the beneficiary timely in 19 percent (28 cases) of our sample. Further, 4 HMOs did not send 9 cases to Network Design Group within the required 60 day time frame.

Resolving Grievances. One HMO suspends action on grievance cases while awaiting medical records. If records are not received, cases remain closed without resolution. One other plan had seven while another had two unresolved grievance cases that were either suspended without resolution or closed without resolution.

Documentation. Eight HMOs had undated initial determinations or did not have them on file in 46 appeals cases (32 percent of the sample). Five plans had 25 appeal cases (17 percent of the sample) where there were no dates on the reconsideration determinations or they did not have them on file. Five HMOs did not have documentation supporting that beneficiaries were notified of grievance results in 15 cases. Also, 6 had such poor documentation that it was impossible to reconstruct 16 appeal cases (11 percent) and 8 grievance cases (5 percent).

RECOMMENDATIONS

HCFA's Office of Managed Care is making substantial efforts to improve the HMO appeal and grievance processes. It has recently created a work group - Managed Care Appeals and Grievance Initiative - organized to make program improvements in these

functions. In 1995, HCFA's Office of Managed Care revised guidelines used by HCFA Regional Offices in their annual review of HMOs. In addition, HCFA in conjunction with Network Design Group, has conducted training sessions, provided technical assistance, and issued publications to improve HMOs' understanding and processing of appeals and grievances. HCFA plans to revise the HMO/CMP Manual and has received funds to evaluate problems in the area of appeals and grievances. However, as our findings reflect, there are areas where improvement is needed.

We recommend that HCFA

- ***ensure that HMOs correctly distinguish and process appeals and grievances.***

  HCFA can accomplish this during their annual visits to HMOs. However, we suggest that HCFA conduct case reviews as well as examine the operating procedures to determine that appeals and grievances are processed correctly. We also suggest that HCFA focus closely on whether HMOs:

  - are in compliance with all directives in processing of appeal and grievance cases;

  - include appeal rights in all initial determinations sent to beneficiaries; and

  - release initial determinations and reconsideration decisions in appeal cases according to established time frames.

- ***modify the HCFA HMO/CMP Manual to clarify and specify key requirements.*** This can be accomplished by:

  - clarifying the explanation and language required on the appeal and grievance issues to improve HMOs' understanding of the differences and

  - establishing minimum requirements for documentation of appeal and grievance files so that an independent reviewer, based upon examining the files, will be able to follow and understand the adjudication by the HMO.

- ***broaden efforts to formally train HMOs on the appeal and grievance processes.***

  We noted a significant amount of turnover in HMO staff responsible for processing appeals and grievance cases during this inspection. In light of this turnover, there is a need to continue training on a routine basis.

AGENCY COMMENTS

We solicited and received comments on our draft report from HCFA. They agreed with the conclusion of our reports that improvements are needed and indicated that they are working to implement a number of our recommendations. We are pleased

that HCFA agrees that improvements are needed in the appeal and grievance processes, and we recognize that changes are in the process of being made through the Medicare Appeals and Grievance Initiative (MAGI). However, because HCFA's response does not specifically address the recommendations contained in our reports, we are unsure whether the problems identified in our report will be fully addressed through this initiative. As a result, it will be important for HCFA to include in their response to the final report an action plan that specifically addresses each recommendation.

The full text of HCFA's comments is included as an appendix to this report.